STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E528	A. BUILDING _____ B. WING _____	02/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE HEALTH CENTER	440 SE WOODLAND AVE TOPEKA, KS 66607

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of complaint investigations #69833 and #71152.	S 000		
S3110 SS=D	26-41-203 (a) Range of Services (a) Range of services. The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision or coordination of the range of services specified in each resident ' s negotiated service agreement. The range of services may include the following: (1) Daily meal service based on each resident's needs; (2) health care services based on an assessment by a licensed nurse and in accordance with K.A.R. 26-41-204; (3) housekeeping services essential for the health, comfort, and safety of each resident; (4) medical, dental, and social transportation; (5) planned group and individual activities that meet the needs and interests of each resident; and (6) other services necessary to support the health and safety of each resident. This Requirement is not met as evidenced by: The facility identified a census of 10 residents residing in the residential health care center. The sample included 3 residents. Based on interview and record review, the facility failed to notify the physician of seizure like activity for 1 (#1) resident without a history of seizures. Findings included: - According to the clinical face sheet, the facility admitted resident #1 to the residential care center	S3110		

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S3110	Continued From Page 1 on 8/13/13. Review of the physician's admission orders dated 8/13/13 documented the resident with the diagnoses hypertension (elevated blood pressure) and schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought, perception and emotional reaction). Review of the resident's Individual Functional Capacity Screen dated 8/13/13, recorded the resident as independent with activities of daily living and had impaired decision-making. Review of the Negotiated Service Agreement dated 8/13/13 recorded the facility's licensed nursing staff were responsible for monitoring the resident's vital signs, providing medical assistance, emergency response system and review/reporting of changes in physical functioning and cognition. Review of the resident's individualized plan of care dated 8/13/13 included the facility's staff would consult with a local hospital's physicians to ensure medical and physical needs were met for this resident. A physician's order dated 10/8/13 listed an order for Divalproex sodium 2000 milligrams daily at hour of sleep for mood stabilizer related to schizophrenia. Nursing note dated 12/8/13 and timed 3:20 P.M., recorded the staff observed the resident lean against the wall, slid to the floor, and had an apparent seizure. The resident had a stiffened body and tremors. The duration was approximately 30 seconds and the resident's	S3110		

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S3110	Continued From Page 2 pulse was 88. Staff would continue to monitor for changes and provide support. The clinical record lacked evidence the facility monitored the resident's vital signs, monitored the resident's condition, or notified the resident's physician of the event until 12/9/13 at 5:24 A.M. when the nurse's note documented, the resident with no further seizure activity this shift. Nursing notes dated 12/9/14 timed 10:40 A.M., recorded at approximately 8:05 A.M., staff observed the resident on the floor in his/her bedroom without a pulse or respirations. Ambulance arrived and pronounced the resident dead at approximately 8:22 A.M. Staff notified the local hospital and the coroner and left a message with the resident's conservator. On 1/30/14 at 12:50 P.M., housekeeping/laundry staff T stated on 12/8/13 after he/she passed the resident in the hall, the resident leaned against the wall with his/her hands clenched next to his/her chest and slid down against the wall. On 1/30/14 at 10:35 A.M., direct care staff N reported he/she had not worked for a couple days and when he/she returned back to work on 12/9/14 the 24-hour report lacked documentation the resident had a change in condition. On 1/30/14 at 12:25 P.M., direct care staff O reported he/she found the unresponsive resident on 12/9/13 at approximately 8:00 A.M. On 1/30/14 at 12:15 P.M., administrative nursing staff F stated licensed nursing staff should do at least every shift charting and assess the resident for 72 hours after a change in status event. On 1/30/14 at 2:15 P.M., licensed nursing staff H	S3110		

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S3110	Continued From Page 3 stated on the afternoon of 12/8/13 he/she observed the resident sliding down the wall and experienced a slight seizure. Licensed nursing staff H stated he/she checked the resident's pulse and his/her vital signs were okay. Licensed nursing staff H stated he/she reported the information to the next nursing shift, but did not contact the physician and he/she was unsure if staff contacted the local hospital. Licensed nursing staff H stated he/she documented the information in the nursing notes. On 1/30/14 at 2:25 P.M., licensed nursing staff I stated he/she continued to monitor the resident throughout the night for seizure activity. On 1/30/14 at 2:55 P.M., licensed nursing staff J reported when a resident experienced a change of condition, the nursing staff should call the physician to report the change. On 1/30/14 at 11:00 A.M., administrative nursing staff D stated there was no evidence staff notified the local hospital or physician after the resident experienced seizure-like activity. Administrative nursing staff D reported the staff should have notified the doctor and continue to monitor and assess the resident every shift for 72 hours. Review of the facility provided undated policy, Notification of Change, documented, "It is the policy of the facility to inform the resident, resident's legal representative, and physician when there is a change in the resident's condition. Clinical care problems and significant changes in condition of residents must be communicated to the resident's physician or the facility medical direct in a timely, efficient, and effective manner. Licensed nurses have the responsibility of contacting a physician any time they believe a resident has developed a clinical problem which	S3110		

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S3110	Continued From Page 4 requires physician intervention". The facility failed to notify the physician after a change in condition for this resident.	S3110		